

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155705</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N HUNTINGTON AVE WARREN, IN 46792</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/29/15</p> <p>Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380</p> <p>At this Life Safety Code survey, Heritage Pointe was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section consisting of 1A and 1B and 2A and 2B was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Hard wired smoke detector were provided in the resident rooms. The facility has a capacity of 186 and had a census of 141 at the time of this survey.</p> <p>All areas providing customary access were sprinklered. All areas providing facility services were sprinklered except two detached barns used for the storage of the facility bus, facility cars, trucks, mowers, snow plows and maintenance supplies and another garage used for the storage of the golf cart.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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